

7-1989

Digest of the Philadelphia College of Osteopathic Medicine (Summer 1989)

Philadelphia College of Osteopathic Medicine

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DIGEST

S U M M E R 1 9 8 9

PCOM Alumni Ply the Delaware
as Physicians Compete in Liberty Challenge



While tracking down

952 of our alumni/ae

who graduated from '65 to '79,

I was filled

with pride and admiration

for the service

they are performing.

Sixty-four percent of you

are involved in primary care,

and 26 percent practice

in rural and industrial towns.

Government reports

frequently cite

problems of physician

maldistribution

and the shortage

of primary care.

Our graduates are not

part of the problem. . .

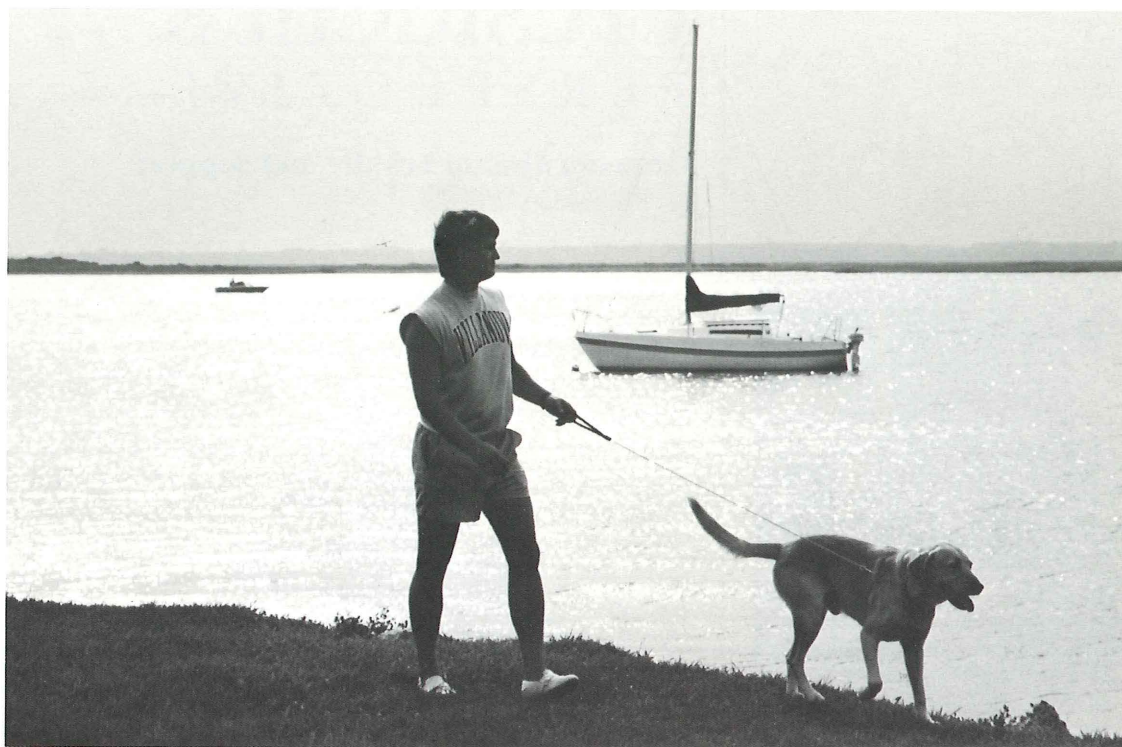
They are part of

the solution

and the increasing strength

of osteopathic medicine nationally.

Robert G. Cuzzolino, Ed.D
Assistant Dean, PCOM



DIGEST

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THE President's P E R S P E C T I V E

Growing Alumni Loyalty and Support

By J. Peter Tilley, DO

I'm really encouraged by the current trend toward increased alumni/ae support, and want you to know how much I appreciate your loyalty to PCOM. It is crucial to the continuing success of this college.

By topping \$580,000 this year, the PCOM Annual Fund broke its own record for the fourth consecutive year. Contributions were received from 100 more donors this year than last, adding a whole legion to the ranks of committed graduates who remember their years of training and care about the fortunes of the college.

This year, the college also received a very gracious, anonymous gift of \$100,000 from a private foundation in honor of a deceased graduate and former faculty member. Substantial gifts like this are facilitated by the mounting evidence that our alumni truly believe in the future of PCOM and the osteopathic profession itself.

Every year brings new class anniversaries, and our 1990 reunion celebrations promise to be events of signal enthusiasm and sharing. For the first time in the history of the college, ten anniversary classes dating back to 1940 have accepted the goal of achieving 100 percent participation by their members in a special class gift to the college. If you are a member of the graduating class of 1940, 1945, 1950, 1955, 1960, 1965, 1970, 1975, 1980 or 1985, you will have an opportunity to show the unanimity of your class spirit and appreciation.

The gratifying response to the Confidential Opinion Survey taken last spring also demonstrates substantial alumni/ae interest in their alma mater. The larger than expected response means that tabulation of the results will take longer than anticipated. However, initial scanning of the returns indicates that you have given us perspectives that will prove valuable to our planning for the future. I thank each one of you who spoke to us in this way, and look forward to hearing what your collective voice is saying to the college.

During the coming academic year, I intend to pursue the open dialogue stimulated by the survey. Personally, I will contact as many alumni/ae as possible to talk about the needs of the college and opportunities for your involvement.

Alumni commitment and participation help us build stronger links with the wider constituency served by the college. I plan to strengthen PCOM's relationship to city and state government as well as the broader community nationwide. Political and corporate/business leaders need to appreciate the benefits offered by this college and hospital, and to realize the critical challenges we face as the nation's largest center for osteopathic teaching and health care.

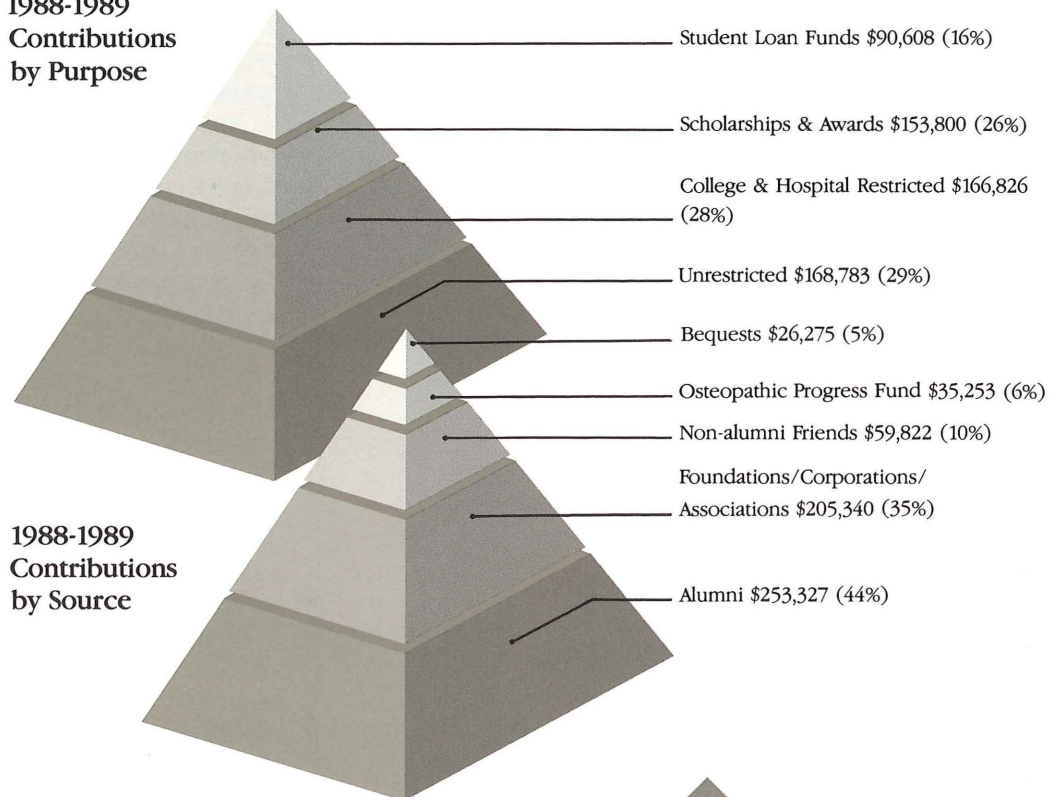
Your college is aggressively making connections to the people, the programs, and the funds needed to maintain its position as a leader in the field of health care, and we will continue to nurture these relationships energetically. I hope to have your willing support for these initiatives, and thank you again for the growing interest you are showing in PCOM.

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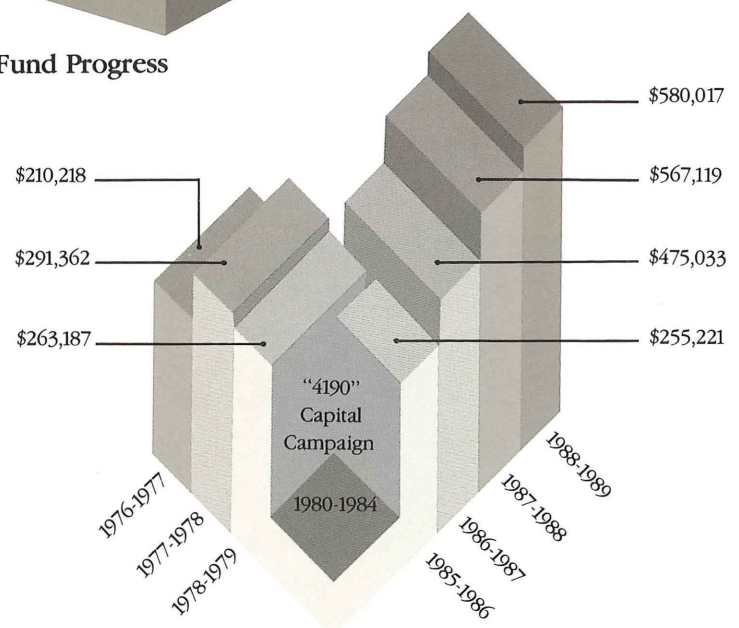
1988-1989 Annual Giving Tops \$580,000

1988-1989 Contributions by Purpose



1988-1989 Contributions by Source

1976-1989 Annual Fund Progress

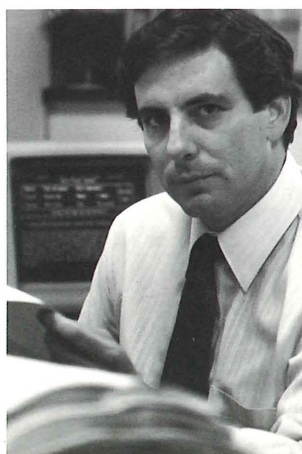


Alumni in Practice

On the Trail of the PCOM Grad . . . Where You Come From and Where You Go

by Robert G. Cuzzolino, Ed.D
Assistant Dean for Educational Resources

Research confirms
some images . . .
PCOM has of its alumni . . .
a strong tendency
toward primary care (64%),
and significant numbers
practicing in rural
and industrial towns (26%)
and serving patient
populations at all
socio-economic
levels.



"Process and product" are important distinctions made by industry. Process is the means of creating the all-important product. Market research will spend millions to find out how well a product works, whether it meets consumer needs, how the market responds, and where the product is utilized.

Medical colleges are so involved with educational process that important questions about practice results often go unanswered. From student selection to curriculum and instruction, our efforts are dedicated to producing the well-trained PCOM graduate. We rethink and revise our educational process continually, but we know little about "our product," the practicing DO.

Compelling Questions

Assumptions abound in medical school admissions committees. Surely the sons and daughters of farmers and rural towns tend toward primary care practice in small towns. And the children of highly educated parents from cities will gravitate toward urban specialty practice. Are both assumptions correct?

The range of physician services provided, the type of patient served, and where physicians practice are issues that have grown from mild curiosities to national concerns. Numerous recent reports outline the maldistribution of medical care and governmental programs designed to direct America's corps of new physicians to primary care and medically underserved locales.

Where does PCOM stand; are our assumptions about PCOM's primary care product based on fact? Do our efforts to recruit a heterogeneous student body influence the real life practices of our graduate physicians? The questions are compelling; my search for answers had to be systematic and precise.

Sophisticated Handicapping

If you graduated between '65 and '79, you received a questionnaire in 1987 as an alumnus included in the research sample. Of the 1,877 questionnaires mailed, 952 were returned, representing a return rate of 51%.

Computer magic allows the researcher to subject large data sets to rather elegant statistical analyses. Millions of mathematical steps are performed in seconds, making short work of complicated methods of weighting each variable and establishing the best

possible equation for predicting practice type. Then the computer tests this equation against the actual data to determine if the model works any better than random chance.

The statistical method was a form of multiple regression analysis called "discriminant analysis." The basic idea is fairly simple. Imagine all the possible combinations of these three professional practice characteristics — (1) primary care versus specialty practice, (2) a patient population of high, middle, or low socio-economic level, and (3) an urban, suburban, or small town practice locale. The possible combinations yield 18 different models of professional practice.

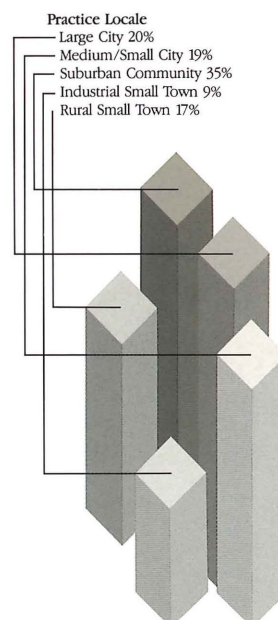
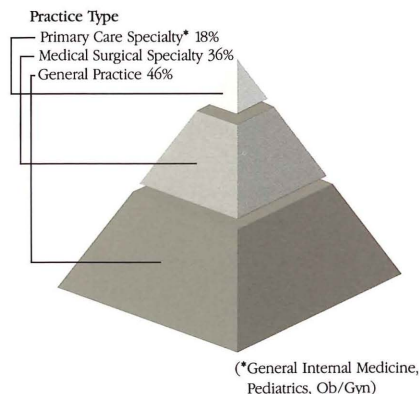
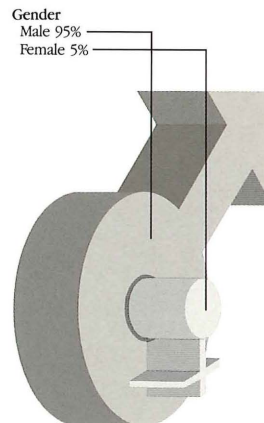
Place the 18 models on one side of the statistical fence, and on the other side put student characteristics such as hometown type, parental education and occupational category, gender, PCOM class rank, and National Board Scores. Discriminant analysis crunches the numbers and tells us how well we can predict membership in each practice model based on student characteristics, which characteristics are most important in the prediction, and which ones have little impact.

In other words, it's a sophisticated form of handicapping. Bettors try to predict win, place, or show among a field of horses by calculating their track records, the jockey, past performance in the mud, etc., in a less scientific manner. For the record, I choose horses with catchy names.

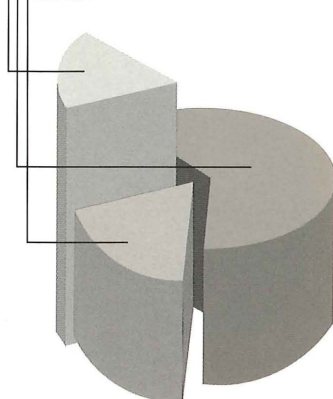
Descriptive Statistics

Are you interested in what you look like as a group — classes 1965 through 1979? The accompanying charts and graphs give the descriptive statistics in summary form.

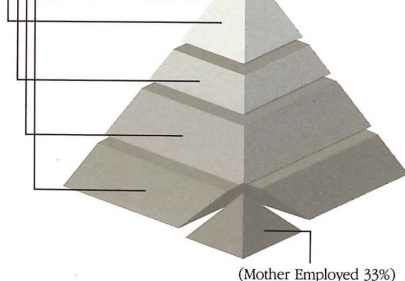
The figures are encouraging because they affirm some images the college has of its alumni. There is a strong tendency toward primary care fields (64%), and a significant representation of alumni practicing in rural and industrial small towns (26%) and serving patient populations of lower socio-economic level (25%). As a group, PCOM graduates are well-dispersed among the various practice models, but are not part of the physician maldistribution problem cited by government reports.



Predominant Socio-economic Level of Patients

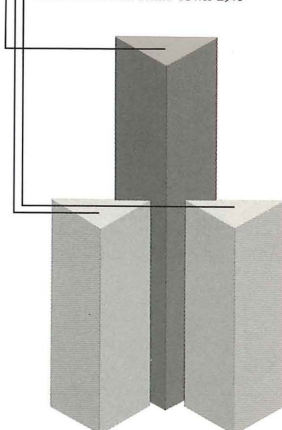


Father's Occupation



(Mother Employed 33%)

Hometown Type



Impact of Student Characteristics

Some student characteristics correlate. In the first stage of analysis, the correlation between parental education and parental occupation was strong, as expected, but suburban origins do not necessarily go hand in hand with more educated parents. We were surprised to note that PCOM class rank and National Board Scores are not strongly related, indicating that these two academic statistics measure different forms of learning.

The analysis also affirms some common assumptions about practice decisions. General practitioners tend to practice in smaller communities and serve patients of lower socio-economic status. Less than 21% of the specialists practice in small towns, and among all suburban practitioners, 90% serve predominantly middle or high socio-economic level patients.

When each student characteristic is analyzed for its effect on each practice characteristic, the statistics allow some very interesting conclusions that are set apart in the box at right.

The Predictive Challenge

Many studies have produced similar results when limited to the comparison of one student characteristic with one practice characteristic. The challenge of this research was to compare all student characteristics with all of the practice characteristics in order to see if the former could predict the latter.

Not all of the 18 practice models are predicted by the student characteristics in combination. Several models, however, are remarkably predictable, especially if one admits the impossibility of weighing all factors (e.g., spouse's preference, role of a mentor) involved in choices of where to practice, whom to treat, and whether to enter primary care or a specialty.

The most predictable model of all is the suburban specialist treating patients of a high socio-economic level. The computer's equation correctly predicts 43% of these physicians whereas random chance would have predicted only 6%. The most important student characteristics driving this predictive function are — suburban hometown, highly educated parents, and high class rank in medical school.

The model representing small town primary care physicians treating patients of lower socio-economic level is also well-predicted. The main factors in the prediction are small town origin and parents with

**Six General Conclusions:
Who Goes Where and
Does What to Whom?**

1. Physicians from small towns enter general practice, and a significant proportion of them return to small towns to practice medicine.
2. Although more than half of the city-bred physicians return to urban areas to practice, the other half still shows a greater probability of practicing in rural or industrial small towns than do physicians who grew up in the suburbs.
3. Parental education level does not influence where a physician will practice or what type of patients he or she will treat. Higher parental education level does, however, propel students toward the specialties.
4. If a student has a father employed in business/management or in the professions, it will influence the student to enter specialty practice.
5. Student gender influences nothing. Males and females follow the same patterns in all of the professional practice characteristics.
6. National Board Scores also show no influence on practice characteristics, but a high class rank does influence the student to enter a specialty.

fewer years of formal education. The urban counterpart of these primary care physicians, who also serves patients of a lower socio-economic level but in the city, is determined by an urban hometown and lower PCOM class rank.

Admissions committees correctly assume that a student's background will influence the type of practice that he or she will enter, but not all commonly held assumptions are true. The return of "a prodigal" to a small rural or industrial town as a family doctor is at least partly supported by the research. However, if you transfer that logic to the urban student, it doesn't work as well. Except for those treating poorer patients in urban primary care practice, city-bred students are the most flexible and dispersed in their career choices.

On the other end of the spectrum is the student with a suburban background and highly educated parents. The strong predictability of this student's return to a suburban community to treat patients of a higher socio-economic class can provide PCOM and other medical schools with a glimpse of the future by taking a quick look at the freshman class.

The reader should not infer that one practice model is more noble than another. I'm convinced that all PCOM graduates are fine doctors, and it's confirmed when I meet alumni/ae or hear applicants speak of their DO mentors. Yet, as medical schools are held more accountable for the corps of physicians produced, knowledge of how student selection affects practice realities makes our task clearer, even as we work endlessly on what goes on educationally in between.

Swinging on the Hinges of Fate

Story and Photography
by George Hatzfeld

The moment between internship and the rest of a physician's practice life is a fast-moving window of opportunity. Decisions made at this critical time are the combination of long and earnest thought, geography, clinical preparation, and just plain luck.



Just a little northwest of St. Petersburg and south of Clearwater, the West Central Florida megalopolis clusters itself briefly in Seminole around several dozen blocks of Alternate U.S. 19, then plunges up the Gulf coast like a tropical storm headed inland, losing momentum as it goes.

It is May, and the combination of humidity and sunshine bring a sultry dampness to the air and sunglasses to the beaded brow of William Furey, DO, '88, who soon will leave his internship year at University General Hospital in Seminole to begin a career as an osteopathic physician. On this day, he climbs inside the present he has given himself for completing his medical training requirements, a new white Honda Prelude, and eases carefully into the northbound lanes of Alternate U.S. 19, his sunroof open to the sky.

"What I like about being down here is independence," he says matter-of-factly. "I came here for my internship because I acquired it; I didn't have anyone pull for me or make a phone call. I earned this on my own."

Winding up his internship, Bill Furey, DO '88 stops to check a chart with a nurse at University General Hospital in Seminole, Florida. The hospital's friendly environment beckons. One of his options for practice is a direct connection here.





In addition to the Seminole, Florida, hospital's bid of guaranteed income, there is a partnership opportunity with a surgeon not far away. Furey leans against his new Prel-

ude and sorts through the pros and cons of these practice offers, weighing them against the open invitation he has for a family partnership in New Jersey with his father.

Bill Furey drives for a few minutes, aiming to take another look at the office site where he may start hanging his shingle as a family practitioner. He talks about his current list of options-- three--and his wrestling match over just which one will win out.

He thinks about a deal the hospital administrator has offered him. There would be a guaranteed income to offset the costs of building a practice, an expected net of 15 patients a day, lower than his two other options. He could admit to other hospitals within a 15-mile radius at the patient's request, but otherwise, both patients and lab work come to the hospital. "My incentive is building my practice and breaking even the first two years," Furey analyzes. "The hospital's incentive is a controlled source of patients."

The internship had been easier than others he might have taken. Most of the rotations were right here in University General, a 140-bed osteopathic acute care community facility with a substantial Medicare population. He'd worked block nights--a month of nights at a stretch--versus a rotating night schedule. His obstetrics rounds had been at Sun Coast, a larger osteopathic hospital five miles away. "I always liked this area," Furey says. "We vacationed here a lot, and my sports medicine rotation was at this hospital. I liked the staff; they were friendly, educationally as well as socially."

The Prelude swings into a yucca-and-palmetto bordered parking lot with room for 30 cars in front of a pair of handsome low brick professional offices. "It's ironic," Furey observes. "On the right is the building where the hospital would help me establish my practice; on the left is my second option with the surgeon."

"The surgeon" is an osteopathic physician looking for a family medicine junior partner. Furey eyes the building on the left. "I know what I'd be making with him," he nods. "I'd be on salary the first two years, and that's more stable for me. In three years I could have a 50/50 practice, but it wouldn't be *my* practice."

Still, the partnership idea sounds workable. Furey expects to work hard from the start, but he looks ahead toward time spent with a family, and knows choices will be made. "It's so easy to get caught up in medicine, it's a 24-hour, seven-day-a-week job. That's one of the advantages of a partnership deal, the load can be split."

The conversation turns to Donna Gioffre, his fiancée, an intensive care nurse at Childrens Hospital of Philadelphia, and their plans to be married August 5 at

Villanova, where both attended college. They had met on a high school trip to France and Spain. Several months before, both had survived a near-tragedy when their car was broadsided by a driver trying to beat the traffic. Furey, gunshy, keeps his eyes on the side streets.

"Initially, I was going to do what *I* wanted to do," he admits. "But as I get closer to the wedding day, I definitely want her input. I don't want to be down here and have her unhappy; I want a well-rounded environment. Ideally, I think she would like to be in New Jersey, near her family in Delaware..."

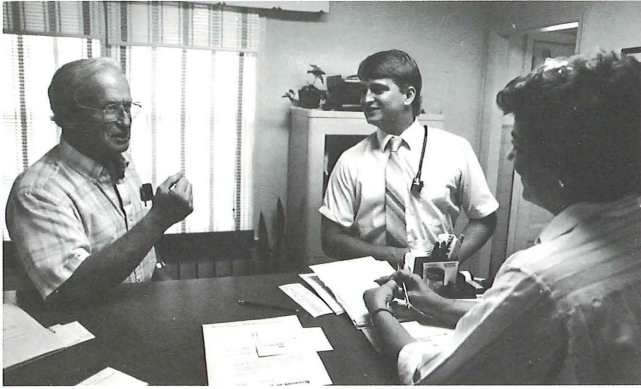
It is late July, and the flowering mimosa trees shading the comfortable home of Robert J. Furey, DO, '52, in Wildwood Crest, New Jersey, sway in the onshore breeze. Bill Furey grew up here, the fifth of seven children, watching his father outgrow a general practice on the first floor, seeing it move and remain in the house next door. Doctor Bob had dismissed suggestions that he run for mayor a few years back. The patient volume was predictably seasonal, but winter invariably brought other demands for continuing medical education, professional committee work and always, the family. Had enough excitement, he said.

The trip from Seminole to the Furey home in Wildwood Crest early in July had been smooth, with Donna flying down to help celebrate, then wedging belongings, themselves and Bill's yellow Lab, Surf, into the Prelude for the drive north. Talk had been about the wedding and about a sudden turn of events in the final days of the internship. Now, as Bill and Donna reflected on offers and contracts, Bill thought he had it figured out.

"The day before I left," he explained. "the surgeon sent me a tentative contract to sign. Everything we had agreed on earlier had been changed: base salary, exit clauses, non-compete clauses. If it hadn't worked out, which was a possibility, it left me in a bad position. I decided not to go that way."

"The hospital deal was too financially binding. I would have had to pay for equipment and maybe even take out some loans. I needed a transitional phase, be able to evaluate the area for a couple of years. The hospital wasn't it."

Furey's third alternative was coming back to the Wildwood Crest office and going into practice with his father, eventually taking over the practice. It was his mother's ideal scenerio for him--an agreement in which

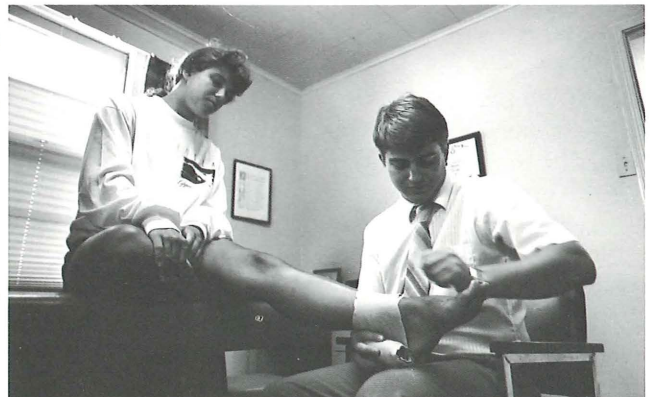


Home for the summer, Bill Furey takes up family medicine with his father, Robert J. Furey, DO '52, sharing the Wildwood Crest offices as a working partner. Doctor Bob and Nurse Receptionist Janice Grookett help the younger Furey get off to a good start.

Furey slips away at the end of a hot afternoon for a bayside walk with Surf, a frisbee hotdog who accompanied the young physician through his Florida internship. The future presses in. Just days away Furey will become a married man, and his decisions multiply.



Lifeguard Angela Cotellese appears for treatment of a sprained ankle, and Furey bandages it sympathetically. He grew up with the ocean at his feet and was a lifeguard himself for many summers. The experience translates now into a bent toward sports medicine.



Bob could relax in the winter but come back to share the practice with his son during the busy tourist season. "Every time I talk about Florida," Bill muses, "my mother has a look of concern, some disappointment, I guess. One, she'd like to have me in the area; two, she'd like the practice here to continue in the family name. My dad feels the same way, but he wants me to take the best opportunity. I appreciate that."

Summer was to be the litmus test. Bill and his Dad would share hours and responsibilities, Bill and Donna would get married, a honeymoon, some time on the beach--it all had a nice ring to it.

But at the internship graduation dinner in Seminole, a conversation with an attending physician from the community had shifted his prospects to a new possibility after the summer's end: An offer of hourly work with a 15 percent incentive in an established practice, no contract, ER time to supplement the base income, a chance to look things over. Furey hadn't signed anything, but it seemed a perfect solution. "We left on a good note, feeling this is exactly right. I would still be admitting to the hospital in Seminole; that would have satisfied them in a way, too."

Donna was getting more excited. "I think she had some anxiety about coming down there in September," Furey says. "She's close to her family, but I think this new development made a difference. She said to me, 'You're so lucky. This just opened up at the last minute, and it's the answer to all our problems.' Knowing we could make that decision made her feel more secure."

Once on the Jersey shore, Furey was surprised how easy the transition into the Wildwood Crest office turned out. Most of the patients were one-time summer tourists with ear infections, viruses, a little hypertension. All were new to Bill Furey, working for the first time as a newly licensed osteopathic physician, feeling more comfortable when he could say, "I'm Dr. Furey. Let's have a look at you," and not having to worry about seeing one of his father's older patients, and having them think, "Is little Billy a doctor now?"

In those first few weeks, the teamwork both Drs. Bob and Bill had hoped for emerged. "We've had only one disagreement," Bill reported. "And we put a \$5 bet on whether the patient would have to come back. I have to say I lost \$5; she did fine without the drugs I would have prescribed. Just in this short time, my dad has taught me a lot."

Furey thought about the preparation he'd had--four years of med school, one year of internship. Was it enough for today's family practitioner? Maybe. For tomorrow's? He wondered. The MD's were getting three post-graduate years; there are new medical/legal aspects, plus, that extra two years of supervised practice to tone up...procedures in office surgery, sigmoidoscopes, skills to help him compete in community medicine.

Furey discussed it with some of his PCOM classmates. Their question was, where would he be doing his family practice residency? Furey's response, after a joking "What residency!" was to check out a lead--an opening in the residency class at Kennedy Memorial Hospital in Cherry Hill. Furey contacted Harry Knorr, coordinator of the family practice residency program at Kennedy, who liked what he saw in the applicant. Impressed with this opportunity, Bill weighed the virtues of staying in New Jersey against his most recent attractive get-acquainted offer in Florida.

The residency won. "It's an excellent program," Furey acknowledges. "Financially, it's not that much different from the first year of practice. It's the competitive advantage I'm looking at. On a mixed staff, MD's and DO's, if we want to be equal or better, we need the training. This just fell into my lap. It's a gift from God, and I couldn't turn it down. I think I made the right decision.

"Donna's ecstatic. The family's happy. There's been a lot going on, I'm trying to see patients at the same time, the wedding's coming up, we've started looking for apartments, a lot of busy days ahead."

An expression of triumph and relief dances across his face, and he adds, "Good days, though."





A turning point comes with acceptance into a family medicine residency program at Cherry Hill's Kennedy Memorial Hospital. Harry Knorr, coordinator of the program, talks through the requirements and the practice opportunities with Furey. "You'll get out of a residency what you put into it," Knorr advises. "You can follow around like Casper the Ghost or get very involved." The decision to stay in New Jersey for two years comes naturally after Furey senses the need for additional practice experience.

Furey, his fiancée Donna Gioffre and real estate representative Kate Miller tour a rental home 20 minutes from Cherry Hill with an option to buy. Many tours later, a wedded Dr. and Mrs. William Furey agree to take this house, to have and to hold, at least through residency.



Build a Better Thinking Cap

To Solve a Rehabilitation Medicine Problem, One of Ours Becomes a Patented Inventor

by Ralph Weltge

The patent issued by the federal government on May 23rd classifies it as a neck exercising device and method, and it will appear under the trade name *Neck Trainer*. Offering a number of potential applications for sport trainers and physicians in physical medicine and rehabilitation, this commercial product will be marketed by a fledgling New York company called *Rockett Exercise Concepts, Inc.* The new enterprise may well take off and fly.

The creative mind and body behind it both belong to *Ricky Lockett, DO, '84*, whose teammates dubbed him "Rocket" during his own days of gladiatorial combat on the mud and glory fields of contact sports. The budding entrepreneur says, "I'm a problem solver, of course, but I never thought of myself as an inventor. On seeing a device not working as it should, I considered alternatives to the design so that it may serve its purpose more effectively. Then, one day when I was prescribing exercises for a neck injury case, I thought . . . 'HEY! . . . why not do it this way?'"

A Heady Resistance

"Barbaric" is the way he styles some earlier neck exercise devices. Currently, there are limited methods which allow effective resistive training to the neck muscles, which can be used at home. One was a harness contraption placed over the head, with a line and weight hanging down from the crown like a swinging pendulum. Knowing that women would rarely use it, and that placing weights in a patient's mouth was out of the question, Dr. Lockett had to solve the problem of placing resistance on the neck muscles via the head in a more sophisticated manner.

Once grasped and turned into a useful product, a bright idea usually seems eminently simple and sensible to the beholder who wonders, "Why didn't I think of that." Lockett's 'hey this way' turns out to be a headband with attached latex tubes that are perhaps reminiscent of long, slender braids of hair. The level of resistance can be altered by switching to thinner or thicker tubes, a feature that may appeal to young athletes who want to build bullneck muscles.

Benefits are achieved through two forms of exercise. One is isometric or static in nature, the user working the neck muscles by pulling on the tubes while keeping the head in a fixed position. This is important to people with acute neck injuries who fear any head movement whatsoever because of pain. The other is isotonic or dynamic, a neck exercise difficult to achieve with other types of

equipment. The latex tube end is held still while the head is moved, and resistance is maintained throughout the maximum range of motion by this flexible segment of the spinal column.

No More Excuses

After two years of private practice and a year of physical medicine and rehabilitation training at Kingsbrook Jewish Medical Center in Brooklyn, Lockett knows all the traps of patient noncompliance and planned to neutralize them. "You can't do it all, patients must work with you to achieve recovery. I would show them home exercises, and they'd come back a week later not even close to doing them correctly," he moans. "I needed a simple, dignified and repetitive exercise gadget that you can roll up and put in your pocket. One you can play with while watching TV or lying in a hammock, not requiring special clothes, a specific place, or a trained therapist for workouts. The *Neck Trainer* ends all the old excuses for not doing exercises!"

His germinal idea and passion to see it realized catapulted Lockett himself into the esoteric realms of materials specification, patent registration, incorporation, manufacturing, product marketing, and soliciting investors. "The market is diverse," he projects, "certainly people with neck injuries and athletes in the contact sports. I'm also doing research on the neck and shoulder problems of office workers bent over video display terminals all day. I need to define my primary and secondary markets for sales promotion."

Unless the condition obviates all neck exercises, rehabilitative use has broad application since the patient performs only normal movements with controllable resistance on the musculature, and the number of repetitions can be prescribed. With preseason training, Lockett says that young athletes can set their own exercise programs if they adhere to basic training rules, like giving the neck scheduled days of rest.

Lockett will draw the sports usage line at the 10th grade age level, and specifically promote the device to trainers in the contact sports of football, rugby, soccer, and wrestling where neck muscle strains are frequent among the injuries. "The *Neck Trainer* can not only lessen injuries but increase performance," he maintains. "One thing you learn in football and wrestling is to control the opponent's head because it gives you leverage on controlling other body movements."

A Lot of Leg Work

Dr. Lockett's interest in physical medicine and rehabilitation goes back to his undergraduate work and degree in

physical therapy. He did his internship and a one-year residency in osteopathic manipulative medicine on campus. While practicing in Chestnut Hill, he snapped up the Brooklyn opportunity to do his specialty training.

After charging into the commercial arena with no experience, we asked him if it was tough to find a manufacturer. "Listen, everything is tough," he confesses. "When they say things take longer than you think, it's true. I had to design it myself, experiment not knowing materials like people in the industry do, and put in a lot of leg work to find a manufacturer. Patenting alone went faster than the year predicted; it took nine months, pleasing and pressuring me simultaneously."

Ideas for other therapeutic devices are perking in his creative mind, but Lockett knows that aggressive marketing of the *Neck Trainer* is a crucial remaining step to its commercial success and that of products to follow. He's also investigating boxing, especially the amateur boxing circuit where little kids enter the trade. "In addition to protective headgear, strengthening the neck may retard the pace of a boxer's cumulative brain damage," he feels.

Osteopathically, Lockett knows the vital functions of a strong musculature in improving circulation and holding in place the realignments achieved by manipulation. "We're walking around with the weight equivalency of a bowling ball on our necks," he observes. "To balance your head is good posture, which we lose with bad work habits, fatigue, and just bending over books and desks, putting strains on neck and shoulder muscles."

Dr. Lockett says that his greatest thrill is not based on the possibility of commercial success, but on the availability of an additional tool to enhance recovery and in certain instances reduce injuries.

If Lockett can market 100 million Americans at their desks as office staff, managers, executives, professionals, administrators, students, academics, and bureaucrats . . . his device may become the greatest pain-in-the-neck reliever since aspirin and restructuring.



Ricky Lockett, DO, helps second year student George Dunkelberger study the effects of both isometric and dynamic use of his newly developed Neck Trainer. The device is one of several patented products Lockett expects to bring to the medical equipment market.

The Recruiter's Crystal Ball

By Virginia Simon
Illustration By Bruce McNeel

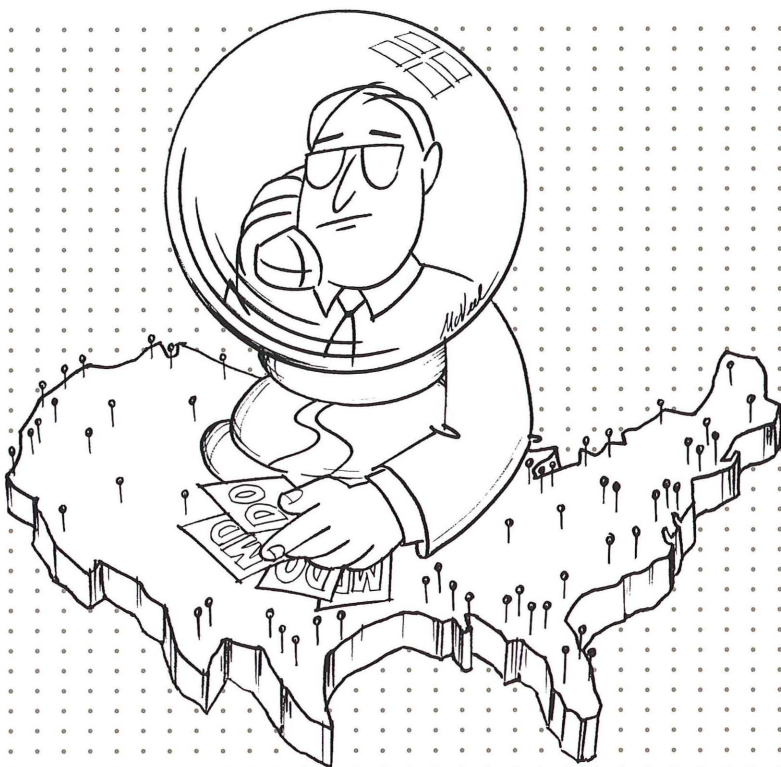
The prognosis is good and getting better for alumni/ae of osteopathic medical schools, according to physician search firms that work both regionally and nationally. At the same time, many of the old misconceptions about the osteopathic profession remain and in some cases limit practice opportunities. But times are changing, and the movement is positive. ☉

Goals and Shoals

Recruiters agree that job opportunities depend on the goals of the graduating DO. "The prospects are good depending on the individual's level of expectation," explains Mike Taylor, vice president of Cejka and Company, a national physician search firm based in St. Louis, MO. Expectation covers a number of areas including geographic preference, practice type preference, and specialty.

Currently, 50 percent or more of all DOs are in general practice versus less than 10 percent of all MDs. And it is still in the primary care areas that osteopathic physicians are most likely to be readily accepted and needed. As MDs increasingly go on to specialty training, the demand for general practitioners and family practitioners will grow, thus creating

What Head Hunters Are Saying about Practice Opportunities for DOs



more opportunities for osteopathic physicians who choose to stay in the primary care areas.

However, recruiters also agree that as more and more osteopathic physicians go on to advanced training in both allopathic and osteopathic programs, there will be increasing acceptance in places and institutions formerly dominated entirely by allopathic physicians.

Geographic preference is another determinant of job potential. Traditionally, osteopathic graduates have tended to locate in areas surrounding their medical school. This is really no different than the tendency of graduates from

other types of professional schools. However, given the limited number of osteopathic medical schools, the vast majority of osteopathic physicians can be found in eleven states with the top five being Michigan, Pennsylvania, Ohio, Texas, and Florida respectively. Graduates from allopathic schools tend to be more evenly distributed according to population patterns.

Therefore, in many of the more desirable locations where osteopathic physicians have not historically been present in great numbers, opportunities may be limited at this point. "I think that osteopathic physicians have to consider some of the less

desirable locations because of the perceptions," says Rick Jackson, president of Physician Sourcing and Research, Inc. These perceptions, Jackson agrees, are changing but currently are still an issue in some situations like academic settings.

Military Opportunities

The military, where DOs were not accepted as commissioned officers on the same basis as MDs until 1967, presents a viable option for all physicians but may, in fact, represent specially good potential for DOs. According to John Tunstall, a former physician recruiter for the Air Force and currently a consultant with John Downing Associates, Inc., in Lionville, PA, "Health care in the military is predominantly directed towards primary care including family practice, internal medicine, OB/GYN and pediatrics."

The downside of military medicine is physician compensation. As the gap between MDs and DOs decreases in terms of opportunity, military service may have significant practice potential but does present financial limitations.

Training and Certification

Recruiters also agree that the DO/MD issue in general does not seem to be as important to their clients in recent years as other criteria such as board certification and the country where medical training was obtained.

"Although there is a statistical preference for the traditional MD training route, the issue of an MD versus DO degree is no longer the key factor it used to be," says Taylor.

In fact, some believe that osteopathic physicians may have certain qualities and/or training that will enhance their marketability. "One of the things we've noticed about DOs is that they tend to be good in entrepreneurial positions. They seem to do well in positions that require some sort of marketing skills or business sense," comments Bill Gregory of MedQuest, Inc., in Devault, PA. He cites the example of a recent placement of an osteopathic physician in a community hospital with the title of Director of Ambulatory Services, whose responsibilities include involvement with satellite offices and additional non-hospital based tasks in addition to medical duties. This perception, if accurate, will clearly be a major selling point given the changing, increasingly business oriented nature of health care.

It is important to remember that until 1973, DOs did not have full practice rights in all states, and that the progress of industry acceptance has been relatively quick. "I think there were far greater reluctances and skepticism ten years ago versus today," says John Downing, President of John Downing Associates, Inc. "The criterion is competency — not whether a physician is

an MD or DO. From a consumer point of view, the issue is qualifications made evident by board certification by peers and the quality of the hospital or facility with which the physician is affiliated."

Recruiter's Bottom Line

The bottom line from the recruiters' perspective is the qualifications outlined by their clients for each position to be filled. The recruiter's task is not to make judgments about what the client needs, even though recommendations are in many cases appropriate. Therefore, if a client prefers an MD, that is the criterion which will be used by the firm.

The key distinction seems to lie in the health care industry's perception — a perception which has long historical roots. "Some of the lingering public relations problems can be overcome by being active in physicians' groups that don't distinguish between an MD or a DO degree," suggests Gregory.

It is plain that the perceptions which have resulted in unequal medical practice opportunities are changing at a rapid pace. Clearly, as in any field, much will ultimately depend on the supply of physicians, both allopathic and osteopathic, relative to consumer needs. Supply and demand along with recent strides in advanced training appear to be the keys to increased practice opportunities for the osteopathic physician.

Seventy-Five Measurements Per Second

Computerized Technology Upgrades Neonatal Intensive Care and Facilitates Osteopathic Research

by Bohdan Minczak, Ph.D., and Steven Snyder, D.O.

Recent advances in computer science and biomedical technology have enabled OMCP to take long and swift forward strides in the practice of neonatal medicine. And we're proud of it.

Using the latest and best that technology has to offer, our Neonatal Intensive Care Unit (NICU) is doing neonatal Pulmonary Function Testing (PFT) at the infant's bedside. This amazing equipment will provide staff with instantaneous results, monitor an infant and keep all records, and conserve time for key nursing and medical personnel.

New PeDS Equipment

OMCP was one of the first hospitals in the nation to acquire PeDS technology — short for Pulmonary Evaluation and Diagnostic System — and currently is the only osteopathic facility already utilizing equipment which will one day become standard in the field. Our NICU cares for 160 neonates each year. Ninety percent of the infants have respiratory problems, premature birth being the cause in 75 percent of those cases.

Some of the parameters that PeDS will yield, for example, are measuring how "stiff" the lungs of the newborn are and the amount of resistance to airflow through the tracheo-bronchial tree. Such data is crucial for guiding physicians and staff in determining how hard the infant must work to breathe, and what type of ventilatory support is appropriate to manage the neonate successfully.

Achieving PFT measurements previously was a slow, cumbersome, and unsatisfactory process that was not always physiologically accurate in terms of the smallest premies. By contrast, PeDS can put out 75 measurements per second and dramatically reduce the time required to analyze critically ill infants from several hours to only a few minutes. Furthermore, measurement interpretation by hand formerly took up to six hours, but the computer will calculate the data in a matter of seconds. A whole workday is saved . . . and sometimes an infant as well!

Is Extraordinarily Versatile

PeDS has broad application in the hospital nursery. It enables ventilator "fine tuning" for infants already intubated on support equipment as the physicians make adjustments that will optimize the respiratory pattern. The effects of bronchodilator medication can also be measured.

Term infants with respiratory problems are served as well as the prematures. Using PeDS to follow the progress of each baby, the staff is helping to prevent further injury to fragile lung tissue that can result from mechanical breathing support. This is one of the long-term patient

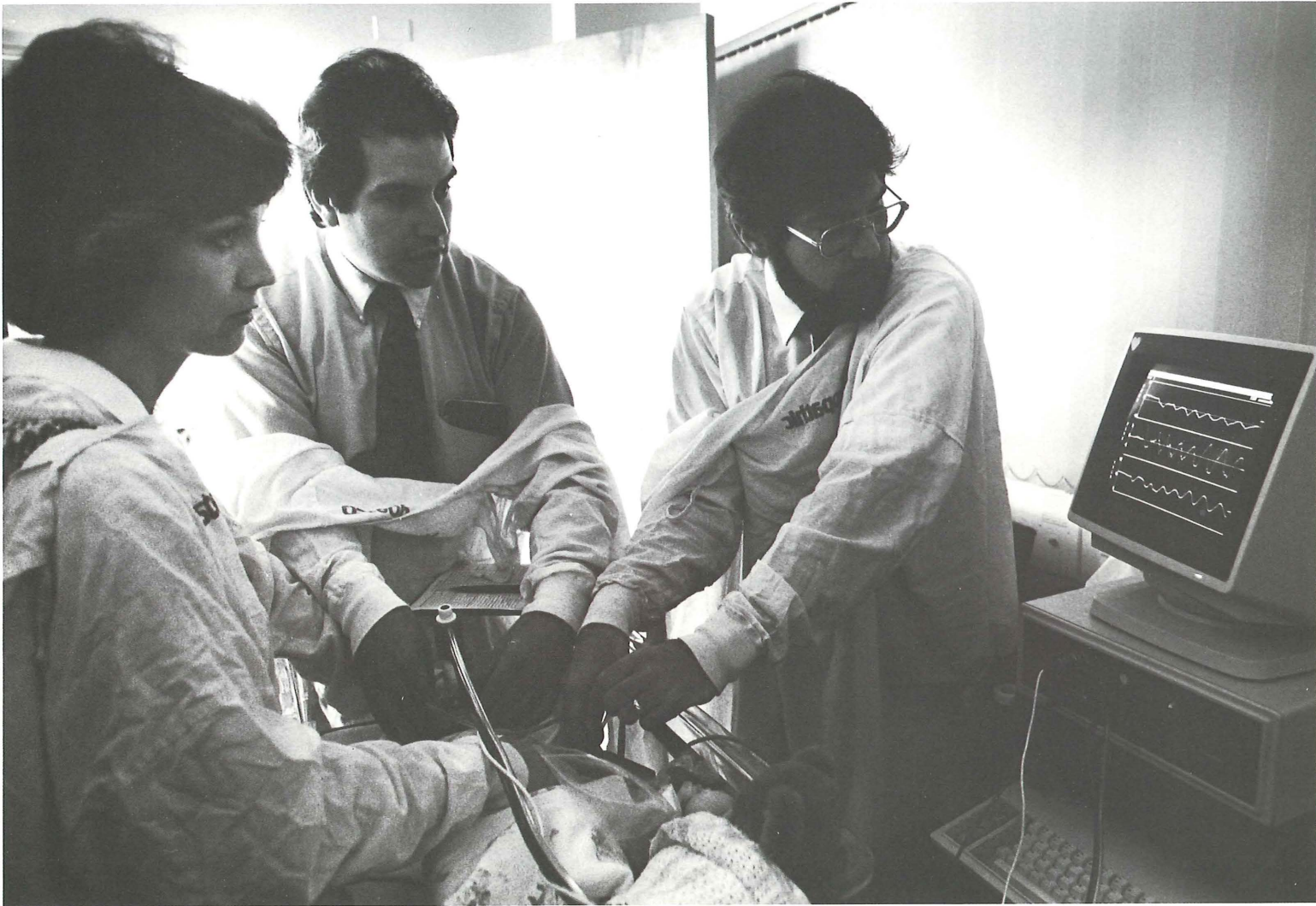
benefits of PeDS and the aggressive care given by the nursery staff.

And Fosters Research

Osteopathic is one of the few hospitals in the Delaware Valley using the PeDS system for clinical research purposes. Having been utilized in the NICU for the past three years, PeDS has already built an important clinical research database. The Division of Neonatal Services, the NICU nursing staff, and the Department of Physiology and Pharmacology are presently designing and initiating a series of research protocols which will eventually produce findings that bridge the disciplines of clinical practice, osteopathic principles, and basic science.

The initial research focuses on comparative lung function of neonates according to weeks of gestation and mode of delivery (whether vaginally or by C-section). Further research will study the effects of current medical treatments on the lung functions of infants with transient tachypnea. The focus of this research is to corroborate osteopathic principles with the practice of modern medical care.





Respiratory problems in neonates can be treated more successfully if their pediatricians can monitor lung capacity and efficiency. Clinician Steven Snyder, DO, and researcher Bohdan Minczak, PhD are working with the latest technology to bridge the disciplines of neonatal intensive care, osteopathic principles and basic science.



Resources for the renovation of the first year classroom in Evans Hall reflect the generosity and osteopathic heritage of the Greer and Gunselman families. Present at the plaque dedication were **Bob and Nancy Greer, Joe and Becky Gunselman, Robert Greer,** and President **J. Peter Tilley, DO.**

The 1989 Vickers Foundation Award was presented to (left to right) **John R. Scranton, DO, '87,** by donors **Frieda O. Vickers, DO, '39,** and **James G. Vickers** in the company of **John D. Angeloni, DO, '75,** under whom Dr. Scranton is doing a general practice residency at Osteopathic Hospital.

Dr. Gilhool Heads Professional Staff

The overwhelming choice is **William Gilhool, DO, FACOI,** as new chairman of Professional Staff. He will serve as liaison between staff, hospital administration, and OMCP's Board of Trustees while implementing the medical practice changes required by state and federal legislation. Among the goals he cites for his two-year term are state of the art medical technology, a more time and cost efficient operation of the SurgiCenter, and vigorous staff representation on patient care issues. Since arriving on campus in 1975, Dr. Gilhool has become clinical professor of Internal Medicine and chairman of the Division of Gastroenterology.

Robert L. Meals, DO, '56, chairman and professor in the PCOM Department of Radiology, Nuclear Medicine and Radiation Therapy, was recently elected to a one-year term as vice president of POMA. He also serves the association by presiding over the Department of Professional Affairs, the Bureau of Professional Development, and the Committee on Radiology.

Emanuel Fliegelman, DO, '42, lectured at SECOM on "Truth Telling, Death, Dying,

and Human Sexuality"; at Suburban General Hospital on "The Effect of Oral Contraceptives and Estrogen Replacement Therapy on Cholesterol"; at the Central Obstretical Society, Harrisburg, on "Myths and Misconceptions of Human Sexuality"; at York Memorial Hospital on "Sexual Dysfunction"; and at the Pennsylvania Osteopathic Medical Assistants convention on "Sexuality and Menopause."



PCOM's Stouthearted Sailors

The Alumni Association sponsored a crew competing in the first Liberty Challenge sailboat races launched on the Delaware River by the Liberty Yacht Club over Bastille Day weekend. At the helm of PCOM's boat was Captain **David Bevan**, DO, '69, and his mates manning the rigging were **James McHugh**, DO, '68, and his son **Patrick**, **Stephen Smith**, DMD, and his son **Wesley**, **Harry Rosenberger**, and **Gary Yeoman**, DO.

The only osteopathic boat in a field representing eight area hospitals, our salts pushed a 27-foot J boat through its paces over a two-mile triangular course off Penn's Landing. Light winds held speeds down to six knots maximum during the three heats, while heavy barge and freighter traffic on the river held out the periodic threat of total disaster.

Captain Bevan says, "We had the best time of all," by which he means great fun and good camaraderie rather than a winning time for the race, which was clocked by Burlington Hospital's boat. Real gentlemen appreciate the pure aesthetics of the sailing sport, a sublime beauty further enhanced in this case by some \$9,000 the event raised for the American Heart Association like a full spinnaker.

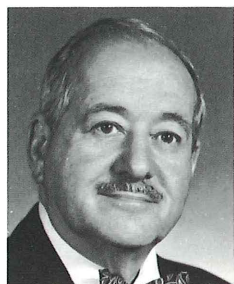


Captain David Bevan, DO '69, with crew on board their J27 after two days of competition in Philadelphia's Liberty Challenge off Penn's Landing.

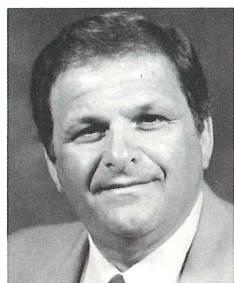
New Bibliographic Resource Available

The 157-page Union List of Osteopathic Literature is a comprehensive source on published osteopathic materials, including books, periodicals, pamphlets, and audiovisuals. This second, enlarged and revised 1989 edition is edited by Shanker H. Vyas, PhD, director of PCOM's medical library. It is subdivided to incorporate subject, author, and contributors' indices together with specifications and notations on the audiovisuals. Eighty two contributors from osteopathic institutions and organizations participated in amassing the list, and information on the location and availability of materials is included. To obtain your copy of the new Union List of Osteopathic Literature, send a \$15 check, payable to PCOM Medical Library, to Dr. Vyas.





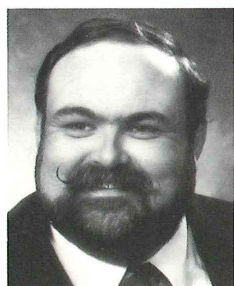
Joseph J. Pellettiere



Michael F. Avallone



Nicholas C. Pedano



Alfred R. D'Angelo

1941

Albert L. Mathews, PO Box 101, El Sauzal, Baja Cfa, Mexico, will host a Golden Anniversary Celebration of class graduation on May 31, 1991, promising a great orgiastic Fiesta at Hotel Las Rosas (31 ocean-front rooms, \$85 double occupancy) only 75 miles south of San Diego. Write . . . he has no phone as Abbot of the Monastery of the Sacred Owl (Pantheist), whatever that means.

1946

Harold H. Finkel, Lancaster, PA, received the ACOP's "Member of the Year" award.

1948

Joseph J. Pellettiere, Atlantic Beach, LI, NY, received the "Physician of the Year" award of the NY State Osteopathic Medical Society.

1952

Hymen Kanoff, Cheltenham, PA, was re-elected as vice speaker of the POMA House of Delegates where he has served for over 30 years.

1954

William G. McDowell, Farrell, PA, was re-elected speaker of the POMA House of Delegates, marking his 23rd year in the post.

1958

Michael F. Avallone, Philadelphia, PA, POMA convention chairman for the past eight years, received the highest recognition bestowed by the association — the Distinguished Service Award.

1961

Andrew Pecora, Cherry Hill, NJ, was appointed president of the ACOI.

Nicholas C. Pedano, Merion Station, PA, was chosen president-elect of POMA.

1965

Martin L. Lasky, York, PA, was appointed president of the Academy of Osteopathic Directors of Medical Education.

1966

John Barbagiovanni, Medford, NJ, was appointed secretary/treasurer at Kennedy Memorial Hospitals/University Medical Center.

Merrill Jay Mirman, Springfield, PA, became a Diplomate of the International Academy of Behavioral Medicine and the American Academy of Pain Management, and lectured on the use of PNI in the treatment of AIDS at the Yale meeting of the International Society for Professional Hypnosis.

1967

Gary D.A. Lewis, Camp Hill, PA, was re-elected secretary/treasurer of the ACOOG.

1968

James Giudice, Haddonfield, NJ, was appointed to the board of trustees of the ACOI.

Carl Mogil, Cherry Hill, NJ was appointed president of the AOA.

Jacques L. Surer, York, PA, was appointed medical director for the Surgical Center of York.

1969

Robert D. Ligorsky, Paradise Valley, AZ, received JAOA press for his work on Sweet's syndrome associated with chronic myelogenous leukemia.

Robert M. Saks, Coopersburg, PA, was certified in general practice.

1970

Louis Papa, Cherry Hill, NJ, director of cardiology at the UMDNJ, became a Fellow in the ACOI and was named "Person of the Year" by the Rotary Club for community service and treating orphan children in Santo Domingo.

1973

Raymond Adelizzi, Cherry Hill, NJ, was accepted as a Fellow in the ACOI.

1974

James D. Lavis, Somers Point, NJ, was certified in Obstetrics and Gynecological Surgery.

1975

Jeffrey A. Lindenbaum, Bristol, PA, announced his general medicine association with two of his former residents, **James J. White**, '87 and **Barbara M. Saracino**, '87.

1976

Ralph E. Aldinger, Reedsville, PA, was certified in Maternal-Fetal Medicine.

R. Michael Gallagher, Chicago, IL, presented or co-presented four papers at the meeting of the American Association

ion for the Study of Headaches, and published in the June issue of Headache.

Charles R. Grubb, Easton, PA, lectured on Lyme Disease at Warren Hospital.

Glenn E. Haas, Langhorne, PA, received JAOA press concerning Coronary artery bypass surgery prior to resection of abdominal aortic aneurysm in patients with unstable coronary artery disease.

Gregory McGinley, Hazleton, PA, was appointed a clinical instructor in the PCOM Department of Internal Medicine.

1977

Andrew C. Friedman, Langhorne, PA, was appointed president of the board of directors, Delaware Valley Medical Center.

1979

Alfred R. D'Angelo, Red Lion, PA, was recently installed as president of POMA.

Susan D. Peck, McConnellsburg, PA, was certified in Obstetrics and Gynecological Surgery.

William A. Wewer, Steelton, PA, was recently elected secretary/treasurer of POMA.

Paul E. Visneski, Lancaster, PA, was certified in Reproductive Endocrinology.

1980

John D. Bender, Philadelphia, PA, is medical director, Department of Physical Medicine and Rehabilitation, Mt. Sinai Hospital.

LCDR J. Grey Brady, USN, Lynnfield, MA, has a fellowship in cutaneous & micrographic (Mohs) surgery at Tufts New England Medical Center, Boston.

Robert B. Contrucci, North Miami Beach, FL, is certified in Otolaryngology, a Fellow of the American Academy of Otolaryngology, Head and Neck Surgery and the American Academy of Cosmetic Surgery, and was elected vice president of the Dade County Osteopathic Medical Society.

Phillip Ginsberg, Wynnewood, PA, received JAOA press concerning Massive hemorrhage secondary to metastatic testicular carcinoma.

Mitchel D. Storey, Seattle, WA, has been team physician for the Seattle Mariners Baseball Team the last four seasons, the only DO serving a pro baseball club in that capacity as far as we know.

1981

Joseph J. Calabro, San Francisco, CA, was elected chairman of the city's Emergency Medical Care Committee and appointed a reviewer for the Annals of Emergency Medicine.

Martin Kanoff, Cherry Hill, NJ, is a part of a PCOM father-

son alumni team elected to the POMA House of Delegates.

1982

Morey J. Menacker, Saddle-Saddlebrook, NJ, was named "Outstanding Clinical Instructor of the Year" at Hackensack Medical Center, the first DO to receive the recognition.

1983

Keith A. Baker, Cape Coral, FL, is one of only 96 physicians awarded the Certificate of Competence in Sports Medicine by AOASM, and serves a medical director for the S.W. Florida Offshore 150 Power Boat Races.

Carol L. Henwood, Pottstown, PA, is senior partner of the Coventry Family Practice Group now in its new facility in the Royersford/Spring City area.

1984

Toni San Maria Casale, Camp Hill, PA, lectured the state chapter of the American College of Utilization Review Physicians on designing quality assurance evaluation programs.

Robert Fiorelli, Philadelphia, PA, received JAOA press concerning Metastasis of prostate gland adenocarcinoma to penile and scrotal cutaneous tissues.

1985

Keith W. Harrison, Douglassville, PA, was appointed to the medical staff at Pottstown Memorial Medical Center and

joined the Coventry Family Practice Group.

Leilani Heller, Zionsville, PA, opened her new practice in Allentown.

Arlene P. Imber, Huntingdon Valley, PA, joined the medical staff at Holy Redeemer Hospital and Medical Center.

Salvatore A. Moscatello, Kennebunk, ME, is a Diplomate in Internal Medicine and has entered private practice of General Internal Medicine.

Michael A. Panariello, Wyckoff, NJ, began a term as chief medical resident at Hackensack Medical Center, and is accepted for a pulmonary medicine fellowship at University Hospital in Newark.

1986

Mark Finkelstein, Wallingford, PA, lectured at SUHS on Radiographic presentations of GI disease and comparative imaging and treatment modalities for pediatric GI malignancies.

Drew A. Koch, York, PA, joined the staff of the Polyclinic Medical Center in Harrisburg, department of emergency and trauma medicine.

1987

D. Todd Detar, Pottstown, PA, joined the Coventry Family Practice Group in Royersford/Spring City this summer. 23

Charlotte Flack McCobb, Millinocket, ME, a life member of the PCOM Corporation, died on April 1 at age 80. She was the daughter of **Arthur Miles Flack**, DO, '06, Dean of PCOM from 1911 to 1924, and the sister of **Arthur M. Flack, Jr.**, DO, '33, who directed the Department of Surgery for many years. A University of Pennsylvania graduate, she taught in the Camden, Collingswood, and Riverside, NJ, schools until her retirement in 1965. Mrs. McCobb is survived by her brothers **B.T. Bailey Flack**, DO, '31, **John B. Flack**, DO, '40, and **Charles B. Flack**, DO, '44.

Eugenia Coffee Norris, '31, Warrenton, GA, died on May 6 of rheumatoid arthritis amyloidosis at age 79. Born in Beverly, NJ, to **Eugene M. Coffee**, DO, '05, and his wife Mary, she was a PCOM honor student. Dr. Norris practiced in Collingswood, NJ, from 1931-1938, was director of health at Asbury College, Wilmore, KY, from 1938-1940, then married and moved with her clergy husband to Georgia where she practiced for over four decades.

Hugh Milton Dash, '33, Brooklyn, NY, died at home on June 11 at age 81. The first Black osteopathic physician to practice in the borough, Dr. Dash was on the staff of Interboro General Hospital in Brooklyn and Manhattan's LeRoy Hospital, and also worked at the Lyndon B. Johnson Health Complex and the

Provident Clinical Society. He practiced until retirement in 1975, and was honored in 1983 by local and national osteopathic associations for his half-century of service to the profession.

Arthur M. Rogers, '38, West Hartford, CT, died on March 9 at age 77 after a very long illness. Dr. Rogers was born in New York and lived most of his life in West Hartford where he practiced for over 40 years. He was a dedicated doctor who loved the profession, a member of the AOA, and had served as treasurer of the Connecticut Osteopathic Medical Society.

Clyde C. Henry, '43, Amarillo, TX, died on February 13 at age 78. A radiologist, he served on the ACOR board, chaired its Committee on Evaluation and Standards, was elected president in 1961, became a Fellow in 1964 and was made a Life Member in 1975. Dr. Henry was also a member of the American Osteopathic Board of Radiology, and chaired the AOA Bureau of Professional Education and served on its Committee on Hospital Accreditation. When he retired in 1981 from Family Hospital Center in Amarillo, he had worked at Philadelphia's Memorial Osteopathic Hospital, Rocky Mountain Osteopathic Hospital, Denver, Flint General and Bay View hospitals in Michigan, and Shenango Valley Osteopathic Hospital in Farrell, PA,

Henry F. Steskel, '58, Oakland, NJ, died recently at the age of 58. After a residency at Portland Osteopathic Hospital, he practiced in Maine and then Oakland where he had a private family practice for over 30 years. An AOA member, Dr. Steskel was on the staff of River Dell Hospital, Oradell, and Kennedy Memorial Hospital, Saddle Brook. During the 60s and 70s, he served on the borough Board of Education and was president of the Board of Health.

Peter Cocco, '62, Philadelphia, PA, died on April 25 at the age of 57 from an acute myocardial infarction that he suffered while playing tennis. Dr. Cocco had a general practice in South Philadelphia for 26 years. Prior to graduation from PCOM, he had already graduated from Temple University School of Pharmacy in 1958.

Paul Rothkopf, '86, Philadelphia, PA, died on May 21 at age 29 from Acute Myelogenous Leukemia. A lifetime member of our Alumni Association, he was associated in family practice with **Dominick Commodaro**, DO, '84, in the Somerton section of Northeast Philadelphia. Dr. Rothkopf was affiliated with the Delaware Valley Medical Center where he did his residency, Frankford Hospital, Saint Mary's Hospital of Langhorne, and Lower Bucks Hospital. He was a member of the AOA and AMA, AAFP, ACOGP, POMA, and the Pennsylvania Medical Society.

Coming Events

September 16	Open House for Families and Friends	PCOM
September 23	PCOM Alumni Rugby Game	PCOM
October 15-18	AOHA Annual Convention	Monterey, Calif.
November 4-11	PCOM - Maui CME Seminar	Maui, Hawaii
November 12-16	AOA Convention	Anaheim, Calif.
January 26-27	Founders Day Weekend	PCOM
January 28 - Feb. 3	Post Founder's Day CME Seminar	St. Thomas
March 24-31	PCOM - Colorado Ski CME	Breckenridge, CO

Osteopathic

Osteopathic Medical Center of Philadelphia
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